ACCIDENT HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Name ______________________ Date___/___/___ AGE___ Birth Date___/___/___

Address______________________ APT#_____ City__________ State_________ Zip_________

Home Phone_________ Cell Phone_________ Work Phone_________ Employer______________________

Employer's Address______________________ City__________ Zip________Occupation______________

If female, are you pregnant?: ☐yes ☐no ☐not sure Date of last period:___/___/___

SSN#______________________Email address______________________

Contact Person in case of emergency______________________( ) -

Spouse's Name______________________ Spouse's Employer______________________

Send appointment reminders via: ___Email ___Text How far in advance: ___1 Day ___4 Hours ___2 Hours

Cell Phone Carrier______________________

INSURANCE & ATTORNEY INFORMATION

Your insurance Co.______________________ Policy#______________________

Name on Policy______________________ Claim#______________________

Agent's Name______________________ Phone#______________________

Address______________________

What are the MED PAY LIMITS on your policy? ☐$5,000 ☐$10,000 ☐Other $__________ ☐Unsure

Other Party's Insurance______________________ Policy#______________________

Name on Policy______________________ Claim#______________________

Address______________________ MED PAY LIMITS $__________ ☐Unsure

If passenger, your Driver's Name______________________ Address______________________ City__________

Zip________ Phone__________ Insurance Co.______________________ Policy#______________

Were there any Witnesses? ☐ Yes ☐ No Names______________________

Your Attorney______________________ Phone#__________ Fax__________

Address______________________ City__________ State_________ Zip________

Any other Insurance______________________ Policy#______________________

Claim#______________________ Phone______________

I understand & agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Harbin/Clymore Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company at the usual and customary fees for said service, and that any amount authorized to be paid directly to this office will be credited to my account. However, I clearly understand & agree that all services rendered me are charged directly to me and that I am personally responsible for payment. In the event my attorney has my med pay payments sent to them instead of this office, I understand that I will be responsible for immediate reimbursement to this office. I also understand that if I suspend or terminate treatment, or my settlement goes beyond 180 days from time of release, any and all fees for professional services rendered me will be immediately due & payable in full.

Patient's Name______________________Patient's Signature______________________Date___/___/___

Guardian's Name______________________Guardian's Signature______________________Date___/___/___

☐Dr. Richard R. Clymore D.C. Doctor's Signature______________________ Date___/___/___

☐Dr. Debra R. Harbin, D.C.

NAME____ DATE___/___/___

ACCIDENT HISTORY

1. Date of Accident: ___/___/___ Time: ______________ ☐AM ☐PM Driver of Car: ________________________
2. If not driver, where were you seated? ☐Front ☐Middle ☐Back ☐Passenger Side ☐Driver's Side
3. Who owns the car? __________________________ Number of people in your car?___
4. Year & Model: Your car: ____________________________ Other car: ______________________________
5. What was the approximate damage to your car? ☐minor ☐major $__________________________
6. What was the damage to the other car? ☐minor ☐major ____
7. Visibility/Road Conditions: ☐poor ☐fair ☐good ☐icy ☐rainy ☐wet ☐clear ☐dark ☐other:_______________
8. In what direction were you headed? ☐North ☐South ☐East ☐West Street name________________________
9. Direction other vehicle was headed? ☐North ☐South ☐East ☐West Street name______________________
10. Type of accident: ☐Head-on ☐Broad-side (__Driver side __Pass. side) ☐Rear-end ☐Single car accident
11. Was your car drivable? ☐yes ☐no Was the other car drivable? ☐yes ☐no
12. Was your car: ☐Stopped ☐Braking ☐Moving, estimated speed______mph
13. How fast would you estimate the other car was going? _____mph
14. Does your car have headrests? ☐yes ☐no
15. Did airbags deploy? ☐yes ☐no ☐front driver ☐front passenger ☐side driver ☐side passenger
16. Did your head or body strike the inside of your car? ☐yes ☐no ☐unsure
17. If yes, What parts of your head or body hit what parts on the inside of your car? ______________________

    ____
18. Did you see the accident coming? ☐yes ☐no Did you brace for impact? ☐yes ☐no Seatbelt on ☐yes ☐no
19. Head position at the time of impact: ☐turned left ☐turned right ☐straight forward
20. Body position at the time of impact: ☐straight ☐rotated right ☐rotated left ☐other: ________________
21. Were you wearing glasses: ☐yes ☐no Did they fly off? ☐yes ☐no Where did they land?_____________
22. Were you wearing a hat: ☐yes ☐no Did it fly off? ☐yes ☐no Where did it land?__________________
23. Could you move all parts of your body? ☐yes ☐no If no, what parts couldn't you move and why?_______

    ____
24. Were you able to get out of your car unaided? ☐yes ☐no If no, why?___________________________

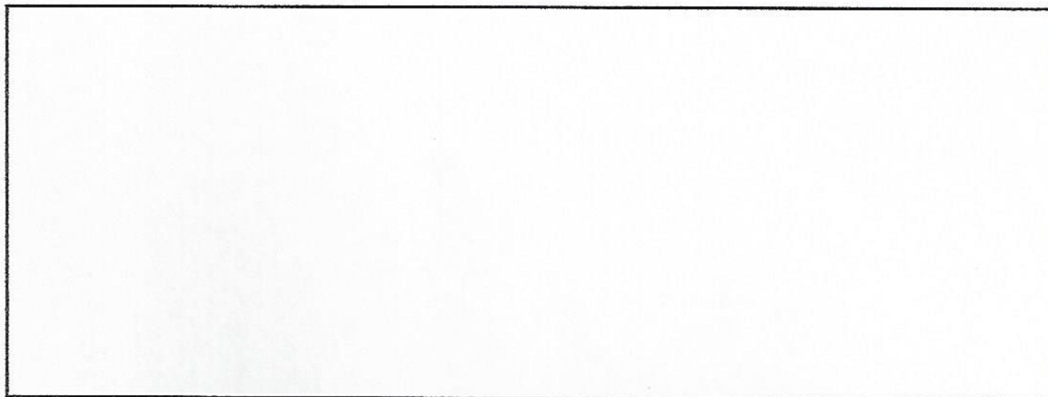
    ____
25. Did you have any bleeding cuts? ☐yes ☐no If yes, where?_________________________________
26. Did you get any bruises? ☐yes ☐no If yes, where?______________________________________
27. As a result of the accident were you?: ☐rendered unconscious (If yes, for how long?)__________ ☐in shock
    ☐dazed, circumstances vague ☐other:____
28. Please describe how you felt:
    Immediately after the accident: ____
    Later that day: ____
    The next day: ____
29. Were there any witnesses that confirmed what happened? ☐yes ☐no Name(s)_______________________

    ____
30. Were the police notified? ☐yes ☐no If yes, by who? ____

    ____
31. Did the police file a report? ☐yes ☐no

NAME____ DATE___/___/___

ACCIDENT DIAGRAM: (DRAW A SKETCH OF THE ACCIDENT)



Patient's description of accident: ____

____

____

____

____

____

ACCIDENT-RELATED SYMPTOMS

1. Check which symptoms you've experienced since the accident:

☐Neck pain/stiffness ☐Headache ☐Dizziness
☐Fainting ☐Memory loss ☐Irritability
☐Difficulty sleeping ☐Fatigue ☐Anxiety
☐Loss of balance ☐Facial Pain ☐ __Clicking __Popping jaw
☐Pain _arms _hands (R L) ☐Numbness _arms _hands (R L) ☐ __Ringing __Buzzing ears
☐Mid back pain ☐Short of Breath ☐Chest pain
☐Low back pain ☐Pelvic pain ☐Pain _legs _feet (R L)
☐Numbness _legs _feet (R L)
☐Other: ____

2. Have you missed time from work? ☐yes ☐no If yes, from___/___/___ through___/___/___
If so, why? ____
3. As a result of this accident, what restrictions in activities have you noted?
☐Bending Neck ☐Rotating Neck ☐Sitting ☐Standing ☐Lifting ☐Twisting ☐Pushing ☐Pulling

NAME____ DATE___/___/___

ACCIDENT-RELATED TREATMENT

1. Did you go to the hospital? ☐yes ☐no ☐Same day By: ☐Ambulance ☐Self ☐Other________________
   Hospital Name____
   If not the same day, what date did you go to the hospital? _____/_____/_____
   Which of the following was performed?: ☐exam ☐x-rays ☐CT Scan____________ ☐MRI____________
   If x-rays were performed, which areas of your spine were taken?: ☐neck ☐mid back ☐low back ☐pelvis
   ☐arms __R __L ☐hands __R __L ☐legs __R __L ☐feet __R __L ☐Other________________
   If MRI was performed, which area?: ☐head ☐neck ☐mid back ☐low back ☐pelvis
   Were medications prescribed?: ☐yes ☐no If yes, what medications ________________________
   ____
   Were injections performed? ☐yes ☐no If yes, what type? ☐Cortisone ☐Epidural ☐Other__________
   To what part of your body were the injections administered?________________________________
   Did the doctor recommend a follow-up visit to a private facility?: ☐yes ☐no
   Did the doctor at the hospital take you off work/: ☐yes ☐no If yes, from ___/___/___ to ___/___/___
2. Have you sought treatment with any other doctor or facility? ☐yes ☐no If yes, where?______________
   ____
   What was the first date of treatment?: ___/___/___ When were you last treated?: ___/___/___
   Are you still receiving treatment?: ☐yes ☐no If so, when is your next appointment?: ___/___/___
   What treatment was provided?: ☐exam ☐x-ray If so, what areas? ________________________
   What medications were given, if any?____
   Were you given a ☐cervical collar or ☐support ☐Other____________ Doctor's name______________
   ____
   Has it helped? ☐No ☐Yes ☐Some Comments: ________________________________
   ____
3. Have you seen any other doctors?____
   What treatment was rendered? ________________________ Are you still treating? ☐yes ☐no

PAST MEDICAL HISTORY

1. Check all boxes that apply and describe (dates, procedures performed, treatment).
   ☐Hospital/surgeries ____
   ☐Auto Accidents (dates, injuries, treatment) ________________________
   ____
   ____
   ☐Work injuries ____
   ☐Illness ____
   ☐Medications____
   ☐Other____
   ☐Past chiropractic treatment________________________________
   Family History: Check all that apply. ☐Tuberculosis ☐Kidney Disease ☐Spinal Disorder ☐Diabetes
   ☐Mental Illness ☐Epilepsy ☐Gout ☐Arthritis ☐Hypertension ☐Cancer ☐Migraines ☐Heart Attack
   COMMENTS: (Office Use Only)____
   ____

NAME________________________________ DATE___/___/___

SYMPTOMS PRIOR TO THIS ACCIDENT

1. Did you have any symptoms prior to this accident? ☐yes ☐no

2. If yes, please list each symptom you had prior to this accident with the appropriate number (indicating the level/severity of each symptom), and letter (indicating the frequency of each symptom) using the chart below: **(example: Neck pain 7C)**

SEVERITY

On a scale of 1-10, with 10 being the most severe, what was the level of pain you had for each symptom prior to this accident?

1 2 3 4 5 6 7 8 9 10

(Mild) **(Severe)**

FREQUENCY

A. OCCASIONAL - Occurs up to 25% of the time

B. INTERMITTENT - Occurs 26% to 50% of the time

C. FREQUENT - Occurs 51% to 99% of the time

D. CONSTANT - Occurs 100% of the time

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10. ______________________